STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	
		155152	B. WING			12/15/2	011
NAME OF F	PROVIDER OR SUPPLIE	R		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					MAIN ST		
MONTIC	ELLO ASSISTED L	LIVING AND HEALTHCARE		MONTIC	CELLO, IN47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		NCY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	+	TAG	BEI ICIENCT)		DATE
F0000							
	 This visit was fo	or a Recertification and	F00	00			
	State Licensure		100		The creation and submission of thi		
	State Electionic	survey.			Plan of Correction does not constitue an admission by this provider of ar		
	 Survey Dates: I	December 12, 13, 14, 15,			conclusion set forth in the stateme	-	
	2011	12, 13, 11, 15,			deficiencies, or of any violation of regulation.	riolation of	
	2011				regulation.		
	Facility Number	r: 000072					
	Provider Number				This provider respectfully requests	that	
	AIM Number:				the 2567 Plan of Correction be	llial	
	THIS I VAINOCI.	100207110			considered the Letter of Credible		
	Survey Team:				Allegation and requests a Desk Re in lieu of a post survey revisit on or		
	Linda Campbell	RN TC			January 14, 2012.		
	Janet Stanton, R						
	Rita Mullen, RN						
	Heather Lay, R						
	-	er, RN (December 12, 13,					
	14, 2011)	or, 10 (December 12, 13,					
	11, 2011)						
	Census Bed Typ	ne.					
	SNF/NF:	88					
	Residential:	6					
	Total: 94						
	Census Payor T	vpe:					
	Medicare: 6	J 1					
	Medicaid: 64						
	Other: 24						
	Total: 94						
	Sample: 17						
	Supplemental Sa	ample: 5					
	Residential sam	-					
		*					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: THWH11 Facility ID: 000072 If continuation sheet Page 1 of 43

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY COMPLETED			
		155152	B. WING		12/15/2011	
	PROVIDER OR SUPPLIER	VING AND HEALTHCARE	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F0151 SS=D	Quality review of Cathy Emswiller The resident has the rights as a rescitizen or resident The resident has tinterference, coercive reprisal from the faher rights. Based on intervier facility failed to a bedtime thus reto bed at a facility deficient practice supplemental ressample of 6. [Resident #28] Findings include A Group meeting 1:30 P.M. Durin Resident #28 ind with being made chosen time each On 12/14/11 at 9	the right to exercise his or ident of the facility and as a of the United States. The right to be free of sion, discrimination, and acility in exercising his or ew and record review, the allow a resident to choose equiring the resident to go by chosen time. The eximpacted 1 of 6 idents in a supplemental example in the concerns to go to bed at a facility	F0151	F 151 Right to Exercise Rig free of reprisal It is the practice of this providensure that every resident hat the right to choose their bedt What corrective action(s) was be accomplished for those residents found to have be affected by the deficient practice? Resident #28 is allowed to choose her bedtime.	der to as ime. ill	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S		
		155152	A. BUII B. WIN	LDING G		12/15/2	
NAME OF I	PROVIDER OR SUPPLIEI		D. WIN		DDRESS, CITY, STATE, ZIP CODE		
					MAIN ST		
MONTIC		IVING AND HEALTHCARE		MONTIC	CELLO, IN47960		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ATE	DATE
	hemiplegia, glauseizure activity a A Minimum Data 11/30/11 indicat	re not limited to, left acoma, and history of after stroke. ta Set assessment dated ed a Brief Interview BIMS] score 15 of 15			residents having the potento be affected by the same deficient practice and what corrective action will be talknown. Residents that are able to	t ken?	
	_	ct]. Functional status			choose their bedtime could be affective by the alleged deficient practice.	ected	
	indicated transfe of two].	ers 3 of 3 [extensive assist on 12/14/11 at 9:50 A.M.,			Interviewable residents wi interviewed to ensure they are be allowed to choose their bedtime.		
	Resident #28 inc	licated for the past 4 to 6			 For those residents unable choose their bedtimes, family mer 		
	· ·	been put to bed before			will be interviewed in order to hon bedtime preferences.		
	that time. She in scheduled bedtir facility census. required a Certif [CNA] to go hor resident indicate up to the evening weeks ago and v [Resident #28] v would be put to related to facility she stayed in her bedtime and required.	ne did not agree or choose indicated the practice of me was related to low. She indicated the facility fied Nursing Assistant me by 9:05 P.M. The indicated this matter graph of the facility of the facility fied Nursing Assistant me by 9:05 P.M. The indicated she before 9:05 P.M. In the facility of the			All residents are allowed to choose the time they go to bed. Staff were re-educated ab allowing residents to choose their bedtime on December 20, 2011, it Staff Development Coordinator. A Post test was administe What measures will be purplace or what systemic changes you will make to ensure that the deficient practice does not recur?	out by the red.	
	A.M., Licensed indicated the fac	v on 12/14/2011 at 10:20 Practical Nurse [LPN] #2 cility did not have a policy ensus and putting residents			Staff were re-educate December 20, 2011 to ensu every resident is given the richoose their bedtime by the Development Coordinator.	re ight to	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPI AND PLAN OF CORRECTION IDENTIFICATION NO	UMBER:	IULTIPLE CON	ISTRUCTION 00	(X3) DATE S COMPLE	
155152	A. BUI B. WIN	ILDING NG		12/15/20)11
NAME OF PROVIDER OR SUPPLIER	•		DDRESS, CITY, STATE, ZIP CODE		
MONTICELLO ASSISTED LIVING AND HEAL	LTHCARE	1120 N MAIN ST MONTICELLO, IN47960			
(X4) ID SUMMARY STATEMENT OF DEFICE PREFIX (EACH DEFICIENCY MUST BE PERCEINT TAG REGULATORY OR LSC IDENTIFYING IN to bed at a scheduled time	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
to bed at a scheduled time. On 12/14/11 at 10:25 A.M., the I of Nursing [DoN] indicated the f did not have a policy related to le and putting residents to bed at a time. 3.1-3(a)(1)	facility ow census		Residents will be interview routinely to ensure they are allowed choose their bedtime. Plans of car all residents will be reviewed and updated quarterly and as needed for bedtime preferences by the interdisciplinary team. Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action. How the corrective action(s will be monitored to ensure deficient practice will not rei.e., what quality assurance program will be put into plate 'Accomodation of Needs' will utilized by the Interdisciplinar team weekly times four, monitimes three and quarterly thereafter to ensure compliant. The CQI committee reviews the audits monthly an action plans are developed if threshold of 90% is not met to ensure continual compliance. The Director of Nursing Services or her designee is responsible to monitor for	the cur, ce? be y thly nce. and the co.	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			istruction 00	(X3) DATE S COMPL	
		155152	A. BUILE B. WING		<u> </u>	12/15/2	011
	ROVIDER OR SUPPLIER	VING AND HEALTHCARE		1120 N N	DDRESS, CITY, STATE, ZIP CODE MAIN ST ELLO, IN47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
					compliance.		
					Compliance Date: January 2012	14,	
F0246 SS=D	services in the factor accommodations of preferences, except of the individual or endangered. Based on interview, the facility resident's accommodations of the individual or endangered.	right to reside and receive ility with reasonable of individual needs and pt when the health or safety other residents would be ew and clinical record ty failed to ensure a modation of preference ated to requested bedtime ats in a supplemental	F02	46	F 246 Reasonable Accommodation of Needs/Preferences		01/14/2012
	sample of 6. (Res	sident #28).			It is the practice of this providensure that every resident hat the right to choose their bedti	ıs	
	at 1:30 P.M. At indicated she had	vas initiated on 12/13/11 that time, Resident #28 I concerns with being d at a facility chosen time			What corrective action(s) we be accomplished for those residents found to have bee affected by the deficient practice?		
	clinical record wincluded but wer	:35 A.M., Resident #28's as reviewed. Diagnoses e not limited to, left coma, and history of fter stroke.			Resident #28 is allowed to choose her bedtime.		
		a Set assessment dated ed a Brief Interview			How will you identify other residents having the potent	ial	

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		A. BUII	LDING	nstruction 00 ———	(X3) DATE SURVEY COMPLETED 12/15/2011
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	12/10/2011
MONTIC	ELLO ASSISTED L	VING AND HEALTHCARE		MONTIC	CELLO, IN47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	[cognitively intac	IMS] score 15 of 15 et]. Functional status rs 3 of 3 [extensive assist			to be affected by the same deficient practice and what corrective action will be take	
	Resident #28 ind weeks, she had b 9:00 P.M. and sh that time. She in scheduled bedtin	n 12/14/11 at 9:50 A.M., icated for the past 4 to 6 een put to bed before e did not agree or choose dicated the practice of ne was related to low.			 Residents that are able to choose their bedtime could be affe by the alleged deficient practice. Interviewable residents will interviewed to ensure they are bei allowed to choose their bedtime. For those residents unable 	l be ng
	required a Certification [CNA] to go hon resident indicated up to the evening weeks ago and w	ed Nursing Assistant ne by 9:05 P.M. The d she brought this matter g charge nurse 4 to 6 has instructed since she			choose their bedtimes, family men will be interviewed in order to hone bedtime preferences. All residents are allowed to choose the time they go to bed.	or O
	would be put to be related to facility was alert and orionand time. She in electric wheelcha	eas an assist of 2, she bed before 9:00 P.M. policy. Resident #28 ented to person, place, dicated she stayed in her hir until bedtime and transfer with assistance			 Staff were re-educated about allowing residents to choose their bedtime on December 20, 2011 by Staff Development Coordinator. A Post Test was administent 	red.
	of two staff at all On 12/14/2011 a Practical Nurse [facility did not he	times. t 10:20 A.M., Licensed LPN] #2 indicated the ave a policy related to utting residents to bed at			What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur? Staff were re-educated	d on
		0:25 A.M., the Director] indicated the facility			December 20, 2011 to ensure every resident is given the richoose their bedtime by the	ght to

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/15/2011
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST	•
MONTICELLO ASSISTED LIVING AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL	ID PREFIX CROSS-REFERENCED TO THE APPROLUCE TAG	BE COMPLETION PRIATE
did not have a policy related to low census and putting residents to bed at a scheduled time. 3.1-3(v)(1)	Development Coordinator A Post Test was administered. Residents will be interroutinely to ensure they are all choose their bedtime. Plans of	viewed owed to
	all residents will be reviewed a updated quarterly and as need bedtime preferences by the interdisciplinary team. Non-compliance with fa	ed for
	policy and procedure may resu employee re-education and/or disciplinary action.	
	How the corrective actio will be monitored to ens deficient practice will no i.e., what quality assurar program will be put into	ure the of recur, nce
	The CQI tool titled 'Accomodation of Needs' utilized by the Interdiscipl team weekly times four, n times three and quarterly thereafter to ensure comp	inary nonthly
	The CQI committee reviews the audits monthl action plans are develope threshold of 90% is not mensure continual compliant. The Director of Nur Services or her designee	y and d if the et to nce.

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI	LE CON	istruction 00	(X3) DATE SURVEY COMPLETED		
THIS TETHY	or conduction	155152	A. BUILDING			12/15/2		
			B. WING STR	EET AI	DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER		112	20 N N	MAIN ST			
MONTICI	ELLO ASSISTED LI	IVING AND HEALTHCARE	MC	NTIC	ELLO, IN47960			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)	
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)				COMPLETION DATE		
IAG	REGULATORT OR	ESC IDENTIF TINO INFORMATION)	TAC	,	responsible to monitor for		DATE	
					compliance.			
					Compliance Date: January 2012	14,		
F0278 SS=D	The assessment n resident's status.	nust accurately reflect the						
	A registered nurse coordinate each as appropriate partici professionals.	ssessment with the						
	A registered nurse the assessment is	e must sign and certify that completed.						
	the assessment m	no completes a portion of sust sign and certify the ortion of the assessment.						
	who willfully and k and false statement is subject to a civil than \$1,000 for ea	nd Medicaid, an individual nowingly certifies a material nt in a resident assessment money penalty of not more ach assessment; or an						
	another individual false statement in	fully and knowingly causes to certify a material and a resident assessment is noney penalty of not more acceptance.						
	material and false		F0270				01/14/2012	
		review and interview, the	F0278		F278 Assessment		01/14/2012	
	[Minimum Data	ensure the M.D.S. Set lassessment			Accuracy/Coordination/Cer	tifie		
	-	ted the skin condition for			d			
		eviewed who had			It is the practice of this provider to			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			ΈΥ		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPLETED)
		155152	B. WIN			12/15/2011	
NAME OF A			_		ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIER	C		1120 N	MAIN ST		
MONTIC		IVING AND HEALTHCARE		MONTI	CELLO, IN47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ensure that each Minimum Data Set		MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	•	n a sample of 17 residents			assessment accurately reflects the skin		
	reviewed. [Resi	dent #64]			condition of residents who have		
					pressure sores.		
	Findings include	y:					
	In an interview of	luring the initial			What corrective action(s)		
	orientation tour	on 12/12/11 at 10:15			be accomplished for those		
	A.M., L.P.N. #7	indicated Resident #64			residents found to have be affected by the deficient	en	
	had an open area	on the right buttock area,			practice?		
	which she acquir	red in the facility.			practice:		
		•					
	The clinical reco	ord for Resident #64 was					
	reviewed on 12/	12/11 at 12:45 P.M.			The Minimum Data Set for	r	
		ded, but were not limited			Resident # 64 was corrected on December 15, 2011 while the sur	vevors	
	_	rome, senile dementia-			were still in the building.		
	1	e, hypothyroidism,					
		nt diabetes, and epilepsy.					
	msumi-depender	it diabetes, and epitepsy.			How will you identify othe	.	
	On 0/7/11 the m	havaiaian andanad			residents having the potential		
	On 9/7/11, the p	-			to be affected by the same		
	~	atment/dressing for			deficient practice and what		
	^ -	o open area right coccyx,			corrective action will be ta	ken?	
	left and right but	tock."					
	1 0 0	MDC					
	_	nange M.D.S. assessment,			· Residents who have pres	sure	
		ssessment period			sores have the potential to be aff	ected	
		f 9/18/11, indicated the			by the alleged deficient practice.		
	resident had no	pressure sores.			· The MDS Coordinator ha	,	
					reviewed all Minimum Data Sets		
	In an interview of	on 12/15/11 at 11:05			residents with pressure ulcers to	ensure	
	A.M., the M.D.S	6. Coordinator indicated			accuracy.		
	an error related t	o pressure ulcers was			· The Minimum Data Set for	r	
	made on that M.	D.S., and she had just			residents with pressure sores wil		
		ected assessment to			accurately reflect their skin condi	tion.	
	accurately reflec	t the pressure sores.			· The Interdisciplinary tean	will be	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE COMPL		
		155152	B. WIN			12/15/2	011	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
MONTICI	ELLO ASSISTED L	IVING AND HEALTHCARE	1120 N MAIN ST MONTICELLO, IN47960					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E COMPLETION		
	3.1-31(i)				re-educated on Minimum Data Set accuracy by the RAI specialist or h designee by January 14, 2012.			
					· A Post Test will be adminis	tered.		
					What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?	into		
					The Interdisciplinary team vere-educated on Minimum Data Set accuracy by the RAI specialist by January 14, 2012.			
					· A Post Test will be adminis	tered.		
					The MDS coordinator will reach Minimum Data Set quarterly as needed for residents with press sores to ensure their accuracy.	and		
					 Non-compliance with facility policy and procedure result in employee re-educati and/or disciplinary action. 			
					How the corrective action(s will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla	the ecur,		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN47960 PROVIDER'S PLAN OF CORRECTION	12/15/2	
MONTICELLO ASSISTED LIVING AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL	1120 N MONTH ID PREFIX	MAIN ST CELLO, IN47960 PROVIDER'S PLAN OF CORRECT		
MONTICELLO ASSISTED LIVING AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL	MONTIO ID PREFIX	CELLO, IN47960		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT		
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT		
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		PROVIDER'S PLAN OF CORRECT	ION	(X5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULI	D BE	COMPLETION
		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JEKIA I E	DATE
		· The CQI tool titled	d 'RAI	
		Process'will be utilized by	y the	
		Interdisciplinary team we		
		times four, monthly times		
		and quarterly thereafter t	o ensure	
		compliance.		
		· The CQI committe	e	
		reviews the audits month		
		action plans are develop		
		threshold of 90% is not n	net to	
		ensure continual complia	ince.	
		· Non-compliance w	vith	
		facility policy and proced		
		result in employee re-edu		
		and/or disciplinary action		
		· The Director of Nu	reina	
		Services or her designee		
		responsible to monitor fo		
		compliance.		
		Compliance Date: January 1	4, 2012.	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/15/2011
		199192	B. WING		12/15/2011
	PROVIDER OR SUPPLIER ELLO ASSISTED LI	VING AND HEALTHCARE	1120	CADDRESS, CITY, STATE, ZIP CODE N MAIN ST CICELLO, IN47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0280 SS=D	incompetent or off incapacitated under participate in plant changes in care at the A comprehensive developed within 7 of the comprehensive an interdisciplir attending physiciar responsibility for the appropriate staff in by the resident's faming representative; and revised by a team each assessment. Based on observatinterview, the fact the Plan of Care services developed Hospice service, entity's responsibility resident #64] Findings include In an interview of orientation tour of the A.M, L.P.N. #7 was receiving Horesident was observed.	care plan must be 7 days after the completion sive assessment; prepared hary team, that includes the n, a registered nurse with he resident, and other n disciplines as determined leeds, and, to the extent litricipation of the resident, ly or the resident's legal d periodically reviewed and of qualified persons after lation, record review and ceility failed to ensure that reflected the care and leed in coordination with a land identified each collities and respective of 1 resident reviewed litring Hospice services.	F0280	F280 Right to Participate Planning Care - Revise CP It is the practice of this provider to ensure that the Plan of Care for exresident with Hospice Service reflet the care and services developed in coordination with the Hospice Servand identifies each entity's responsibilities and respective functions. What corrective action(s) was be accomplished for those residents found to have be affected by the deficient practice? The Plan of Care for Resident #64	ach ects n vice vill en

		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155152	B. WIN	G		12/15/2011
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	
MONTIC	FILO ASSISTED I	IVING AND HEALTHCARE			MAIN ST CELLO, IN47960	
			-		CLLC, 11147 300	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	+	.P.N. indicated the			been reviewed with the Hospice S	
		or the bed was written in			to ensure that it reflects the care a	
	the physician's orders.				services developed in coordination the Hospice Service and identifies	
	the physician's o	riders.		entity's responsibilities a		
	The clinical reco	ord for Resident #64 was			functions.	
	reviewed on 12/12/11 at 12:45 P.M. Diagnoses included, but were not limited					
	_	rome, senile dementia-			How will you identify other	
		pe, hypothyroidism,			residents having the poten to be affected by the same	tiai
		-dependent diabetes, and			deficient practice and what	
	history of pathol	•			corrective action will be tal	
	listory or pathor	rogreat mactares.				
	Although the res	sident had physician				
	_	ol and Morphine Sulfate			· Residents who have Hosp	ioo
	-	s on a P.R.N. [as needed]			Services have the potential to be affected by the alleged deficient practice.	100
	•	rogress notes indicated				
		not experiencing any pain				
		medications had been			· The Plan of Care for resident	ents
		pain in October,			with Hospice Service have been reviewed to ensure they reflect the	o cara
	November, or D	-			and services developed in coording	
		2011.			with the Hospice Service and iden	itifies
	A Hospice admi	ssion form, dated 9/8/11,			each entity's responsibilities and respective functions.	
	-	ident was admitted to the				
	Hospice service				 The Interdisciplinary team re-educated to ensure that resider 	
		· · · · · · · · · · · · · · · · ·			with Hospice Services have a Plan	
	A facility Care F	Plan entry dated 9/21/11			Care that reflects the care and se	
		olem of "Resident has			developed in coordination with the Hospice Service and identifies ear	
	-	tegrity: left/right buttock,			entity's responsibilities and respec	
	•	open lesion." There			functions by the RAI specialist or lidesigneeby January 14, 2012.	IICI
		ches/interventions listed,			· · · ·	
		ng [facility] "Nursing"			· A Post Test will be admini	stered.
		esponsible. The other				
	_	eventions listed were as				
	follows:					
	I				<u>l</u>	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152			LDING	ONSTRUCTION 00	(X3) DATE COMPL 12/15/2	ETED	
	PROVIDER OR SUPPLIEF	I IVING AND HEALTHCARE	D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN47960	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	"Hi low bed;" we disciplines responsation of the respective or extent of care addressed a probre responsation of the receiving hospice."	ith "HP" and "Nursing" onsible. t;" "HP and "Nursing" onsible. d setting at 3;" "HP and olines responsible. on in chair;" "HP" and olines responsible. on 12/15/11 at 10:20 or of Nursing indicated Care Plan meant ditional information care and services were to ach of these approaches, function, responsibilities, for each discipline. Plan entry dated 9/16/11 olem of "Resident is e services related to care to thrive, end stage		TAG	What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur? The Interdisciplinary team re-educated to ensure that reside with Hospice Services have a Pla Care that reflects the care and se developed in coordination with the Hospice Service and identifies ea entity's responsibilities and respectinctions by the RAI specialist or designee by January 14, 2012. A Post Test will be adminited. The Interdisciplinary Tear review each Plan of Care for reside with Hospice Services to ensure the reflect the care and services developed in coordination with the Hospice Sand identifies each entity's responsibilities and respective functions. The MDS Coordinator will Hospice Services of the time and of each Plan of Care review for residents with Hospice Services to ensure they reflect the care and services developed in coordinatio the Hospice Service and identifies entity's responsibilities and respective functions.	will be ints in of rvices ich ctive her stered. in will lents hey loped lervice inotify date o in with is each	DATE
	"Encourage soci tolerated or able and Social Servi	alization/activities as " with Activity, Nursing, ce disciplines to provide. es per hospice plan of			functions. Non-compliance with facility policy and procedure result in employee re-educa and/or disciplinary action.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/15/2011	
	PROVIDER OR SUPPLIEF	IVING AND HEALTHCARE	I	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN47960	•
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR care;" with [facil	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ity] Nursing discipline		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	responsible. [A not found]. "Notify M.D. an pain;" with Licer "Observe for syrverbal and non-worth Nurse, Nursing, responsible. The information to do responsibilities, frequency each of the service. "Provide a sooth family/friend vis "All" disciplines "Provide intervention-pharmacology Document effect with Licensed N Hospice discipling was no additional demonstrate the responsibilities, frequency each of the service. "Turn and repositions and Hospice discipling and Hospice discipling and Hospice discipling the service. "Turn and repositions and Hospice discipling	Hospice Care Plan was d hospice of unrelieved nsed Nurse responsible. Inproms of pain; both rerbal;" with Licensed and Hospice disciplines are was no additional emonstrate the division of or indicate the extent and discipline was to perform ing environment for its with resident;" with responsible. Intions (med or gical) for pain symptoms. iveness or P.R.N. meds;" urse, Nursing, and hes responsible. There al information to division of or indicate the extent and discipline was to perform tion every 2 hours;" with			How the corrective action(will be monitored to ensur deficient practice will not r i.e., what quality assurance program will be put into ple The CQI tool titled: 'Hospice Services' will be ut by the Interdisciplinary team weekly times four, monthly three and quarterly thereafte ensure compliance. The CQI committee reviews the audits monthly a action plans are developed threshold of 90% is not met ensure continual compliance Non-compliance with facility policy and procedure result in employee re-educa and/or disciplinary action. The Director of Nursi Services or her designee is responsible to monitor for compliance. Compliance Date: January 14, 2	tilized n times er to and if the to e. e may ation
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	THWH1	Facility 1	ID: 000072 If continuation	sheet Page 15 of 43

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	A. BUILDING O O O O O O O O O O O O O		COMPI	(X3) DATE SURVEY COMPLETED 12/15/2011	
NAME OF F	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CO		J. 1	
MONTIC	ELLO ASSISTED LI	VING AND HEALTHCARE		NTICELLO, IN47960			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APP	ULD BE	(X5) COMPLETION DATE	
	of diabetes, risk to pain due to history dependent on state grooming, and we 18 entries had apto be provided by In an interview of A.M., the Director the Hospice agent Care Plan conferstaff every visit. Hospice Plan of eseparate binder.	zure disorder, diagnosis for constipation, risk for ry of fractured foot, ff for dressing and eight loss. None of the proaches or interventions the Hospice agency. In 12/15/11 at 10:20 for of Nursing indicated for did not come to every ence, but did talk with She indicated the Care should be in a					
F0314 SS=D	a resident, the faci resident who enter pressure sores do sores unless the ir demonstrates that a resident having precessary treatment	prehensive assessment of ility must ensure that a rs the facility without es not develop pressure ndividual's clinical condition they were unavoidable; and pressure sores receives ent and services to promote ifection and prevent new ping.					
	·	review, interview and	F0314	F314 Treatments/SVCs t	to	01/14/2012	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152			LDING	NSTRUCTION 00	(X3) DATE : COMPL 12/15/2	ETED	
	PROVIDER OR SUPPLIER	IVING AND HEALTHCARE	•	1120 N	DDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	\TE	(X5) COMPLETION DATE
	proactive in the pressure ulcers, history of pressure nursing measure reoccurring pres	facility failed to be prevention of reoccurring for a Resident with a re ulcers, by developing s for the prevention of sure ulcers. This impacted n a sample of 17.			Prevent/Heal Pressure Sores It is the practice of this provid to ensure that the facility is proactive in the prevention of reoccurring pressure ulcers, for a resident who has a history or pressures ulcers, by developing nursing measures for the prevention of reoccurring	or f	
	12/12/11 at 10:1 Resident #20 had ulcer on the righ The clinical reco	l tour with LPN #2, on 0 A.M., she indicated d an acquired pressure			what corrective action(s) what corrective action(s) where accomplished for those residents found to have be affected by the deficient practice?		
	Diagnoses for Resident #20 included, but were not limited to, cerebral palsy, diabetes, seizures and dysphagia. Resident had a gastric feeding tube.				 Nursing measures are in p for the prevention of reoccurring pressure ulcers for Resident # 20, has a history of pressure ulcers. 		
	Resident #20 had	imum Data Set ed 10/26/11, indicated d severely impaired skills and no pressure			How will you identify other residents having the poten to be affected by the same deficient practice and what corrective action will be tall	tial	
	dated 10/26/11, had impaired mo	nd Risk Assessment, indicated Resident #20 obility, slid down in bed ontinent of bowel and			Residents who have a hist pressure ulcers have the potential affected by the alleged deficient practice.	•	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		155152	A. BUII B. WIN			12/15/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	(1120 N	MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	MPLETION DATE
IAG	1	a history of pressure		IAG	,		DATE
	ulcers. The Resident was at risk for				· A skin assessment wi	l be	
	developing skin				completed for current reside		
	developing skin	ordina wii.			by the Nurse Management to by January 14, 2012.	eam	
	An Interdisciplin	nary Team note, dated			by bandary 14, 2012.		
	8/11/11, indicated a wound to the right				· The Physician will be		
	· ·	centimeter) X 1.5 cm X <			notified and plan of care will updated as needed.	be	
	0.1 cm	,			upuateu as needed.		
					· The medical records f	-	
	A nursing note, dated 8/26/11 at 11:30				residents who have a history		
	P.M., indicated "Wound note: Area on right buttock resolved. Cont. (continue) to monitor X 1 more week" A Nursing note, dated 9/18/11 at 10:15				pressure sores will be audite ensure nursing measures ar		
					place for the prevention of	· · · ·	
					reoccurring pressure ulcers.		
	_	"Wound note: Resident			What measures will be put	into	
		opened area on [right]			place or what systemic		
	buttock. Measure				changes you will make to		
	Surrounding tiss	ue [without]			ensure that the deficient		
		nd reposition Q (every) 2			practice does not recur?		
	hrs (hours) [with	good body alignment					
	maintained [with	n] pillowscomposure					
	mattress on bed	for pressure reduction,			Re-education for nurses w		
	speciality cushic	n in w/c (wheelchair)"			given by January 14, 2012 on Pre Ulcer Prevention and Documentat		
					the Assistant Director of Nursing of	r her	
		Pressure Wound Skin			designee.		
		ort, dated 9/18/11,			· A Post Test will be adminis	tered.	
	1	II pressure ulcer to the			Facility (1911)	*h a *	
	_	cm X 2 cm X < 0.2 cm.			Facility utilizes mattresses are pressure-reducing/relieving wh		
	The area was res	solved on 10/18/11.			are in place for all beds, unless the of Care indicates otherwise.		
	A review of the	Pressure Wound Skin			A skin assessment wi	lhe	
	Evaluation Repo	ort, dated 11/2/11,			completed for current residents		
	indicated a stage	II pressure ulcer to the			by the Nurse Management to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155152	B. WIN			12/15/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1120 N	MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	right buttocks, 2	.5 cm X 1 cm X < 0.2 cm.			by January 14, 2012.		
					· The Physician will be		
	I -	easurements were done			notified and plan of care will	be	
	on the following	dates:			updated as needed.		
					· The medical records for		
	11/8/11: 3 cm X	0.8 cm X < 0.1 cm			residents who have a history	_	
					pressure sores will be audite		
	11/15/11: 2 cm	$X \ 1 \ cm \ X < 0.1 \ cm$			ensure nursing measures are	e in	
				place for the prevention of			
	11/19/11: 2 cm	X 1 cm X 0.1 cm	reoccurring pressure ulcers.				
			· The Charge Nurse will ensure		ure		
	11/30/11: 0.3 cm	n X 0.2 cm X 0.1 cm			that nursing measures are in place	each	
					shift for residents who have a historeoccurring pressure ulcers per the	•	
	12/7/11: 3 cm X	1 cm X 0.2 cm. The			plan by conducting rounds.	care	
	physician was ca	alled and the treatment					
	was changed to	duoderm.			· Residents' wound risk		
					assessments are reviewed by the Interdisciplinary team no less than		
	During an observ	vation with the Assistant			quarterly and as needed to ensure		
	_	ing Services (ADoN), on			preventative measures are in place prevent pressure ulcers and/or	e to	
		P.M., the pressure area			treatments to promote healing.		
		X 1 cm X < 0.1 cm. The					
		nk in color with lighter			· The licensed nurse comple	etes	
	_	nding the area. There was			skin assessments on all residents weekly.		
	^	•			,		
	no drainage or o	uoi.			The physician is notified for		
	A Cama Diam 1 4	-110/4/11 f!!			treatment and the plan of care and aide assignment sheets are update		
	· ·	ed 10/4/11, for "			needed.		
	_	n risk for skin breakdown.					
		en areas to buttocks."			 The Interdisciplinary team completes weekly wound rounds for 	nr	
		nursing included:			residents with pressure sores to er		
		ress (6/15/11), check and			preventative measures are in place		
		s. Provide incontinent			to monitor effectiveness of treatme	ent.	
		ncontinent episode, and			· The Unit Manager is respo	nsible	
	turn and reposition	on routinely $(1/5/11)$,			to ensure the skin assessments ar	е	
	Meds and treatn	nents per MD order			completed and the treatments have	е	

					(X3) DATE SURVE	Y	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155152	B. WIN	G		12/15/2011	
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
MONITIO	ELLO ACCIOTED I	NAME AND LIE ALTHOUGH			MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTIO	CELLO, IN47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	PLETION
TAG		ALSC IDENTIFYING INFORMATION)		TAG	been completed and documented		ATE
	, ,,	MD as needed (1/5/11),			ordered.		
		, cushion in wheelchair,					
		th pillows (1/5/11),			 Non-compliance with facility policy and procedure 	may	
	_	D orders $(1/5/11)$ and			result in employee re-educa		
	1	essments on shower day			and/or disciplinary action.		
	, ,	v nursing interventions					
		e to prevent the recurring					
	Stage II pressure	e ulcers since 6/15/11.			How the corrective action(s	.,	
		110/4/11 0 110 11			will be monitored to ensure		
	· ·	ted 12/4/11, for "Resident			deficient practice will not r	ecur,	
	has impaired skin integrity: Stage II.				i.e., what quality assurance		
	_	outtock." Approaches for			program will be put into pla	ice?	
	nursing included						
	_	us clear ointment to					
		after each incontinent			· The CQI tool titled		
	_	ight for protection			'Pressure wounds-treatment		
	(10/27/11), Trea				audit' will be utilized by the	,	
		x spray three X a day and			Interdisciplinary team weekly times four, monthly times the		
	· ·	9/11), assess for pain			and quarterly thereafter to e		
		s wound weekly (11/2/11),			compliance with assessmen	t and	
	_	orsening or no change in			documentation procedures.		
	_	f infection (11/2/11),			· The CQI committee		
	_	g/redistribution mattress			reviews the audits monthly a	nd	
	_	re mattress (6/14/11),			action plans are developed i	f the	
	_	ntal (3/18/11), incontinent			threshold of 90% is not met		
		(10/23/09), pressure			ensure continual compliance Non-compliance with facility	·.	
	_	bution cushion in chair			policy and procedure may re	sult	
	` ′	urn and reposition every 2			in employee re-education ar		
	` ′). No new nursing			disciplinary action.		
		e put in place to prevent			· The Director of Nursir	<u> </u>	
	recurring Stage	II pressure ulcers since			Services or her designee is	9	
	11/19/11.				responsible to monitor for		
					compliance.		
	A "Skin Manage	ement Program," dated					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		(X2) MULT A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPLI 12/15/20	ETED	
	PROVIDER OR SUPPLIER	IVING AND HEALTHCARE	1	1120 N I	DDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	REGULATORY OR 3/2010, received Nursing Service: A.M., indicated American Senior each resident to potential skin in admission, quart significant changskin assessment weekly by the liet to assess overall integrity, and sk plan will be deveresident's needs interventions	from the Director of s, on 12/15/11 at 11:25 "It is the policy of r Communities to assess determine the risk of tegrity impairment, upon erly, annually, and with ge. Residents will have a completed no less than censed nurse in an effort skin condition, skin in impairmentA care eloped specific to the including prevention. The care plan will be addressing any new iew with the ADoN, on P.M., she indicated is a lot of scar tissue on a old pressure ulcers. They heelchair cushion using a body pillow for ed and a composite ite pressure. I Therapy note, dated it "New gel seat cushion the new T-foam ecked gel layer on top, ecked gel layer on top,			CROSS-REFERENCED TO THE APPROPRIA		
	cushion with che and with coccyx						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2012 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
		155152	A. BUILDING B. WING	00	12/15/2011
NAME OF P	PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP CODE	
		IVING AND HEALTHCARE		N MAIN ST TICELLO, IN47960	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	TIOLLEO, 11147 900	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	A physician's ord indicated "Comp	der, dated 6/14/11, osure mattress."			
	A physician's order, dated 8/4/11, indicated "May use Body Pillow for positioning."				
	3.1-40(a)(2)				
F0323 SS=D		nsure that the resident ins as free of accident			
		sible; and each resident supervision and assistance accidents.			
	Based on observation record review, the	ation, interview, and e facility failed to ensure	F0323	F323 Accidents and Supervision	01/14/2012
		re in place to prevent motion sensor and staff		It is the practice of this area.	dor to
		of 4 residents with falls		It is the practice of this provide ensure interventions are in p	lace
	_	7. (Resident # 76).		to prevent falls related to a n	notion

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: THWH11 Facility ID: 000072

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION O0		(X3) DATE SURVEY COMPLETED	
		155152		LDING		12/15/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	R			MAIN ST	
MONTIC	FLLO ASSISTED L	IVING AND HEALTHCARE			CELLO, IN47960	
		STATEMENT OF DEFICIENCIES		ID		(7/5)
(X4) ID PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		,			sensor and staff supervision	
	Findings include	7.			·	
	1 manigs merade					
	On 12/12/11 at 0	9:45 Δ M during an			M/hat a avecative action(a) v	
	On 12/12/11 at 9:45 A.M., during an initial tour with LPN #1, Resident # 76				What corrective action(s) was be accomplished for those	
		s having a history of falls,			residents found to have be	
		and requiring assistance to			affected by the deficient	
	1 -	1 0			practice?	
		ad a prosthesis on the left				
	1 -	t's last fall had occurred				
	when she attempted to ambulate by				· Resident #76 has a m	otion
herself from the bathroom.					sensor that is in place and	
0 10/10/11 110 00 1 15 17 17 1/11				activated when in bed.		
	On 12/13/11 at 10:00 A.M., with LPN #1,				T I (*	
		as observed lying in her			 The motion sensor is the Plan of Care and the Aid 	
		. The motion sensor was		Assignment Sheet for Reside		
		esser behind the door and			#76 .	
		Interview with LPN # 1				
		otion sensor should have			· It is documented on the	ne
	been by the bed	and turned on.			Plan of Care and the Aide Assignment Sheet that Resi	dent
					# 76 should not be left alone	
		clinical record was			using the bathroom.	
		12/11 at 10:45 A.M. The			0. 6	
		the resident was admitted			 Staff will be re-educat about the use of the motion 	eu
	1	which included, but were			sensor while in bed to alert	staff
	not limited to, di	-			of unassisted transfers for	
	_	failure, peripheral			Resident #76 by January 14	
	neuropathy, left				2012, by the Staff Developm	
		d dementia, memory			Coordinator or her designee	•
	problems, and ge	eneralized weakness.			· Staff will be re-educat	ed
					about the need to not leave	
	A Minimum Dat	ta Set (MDS) Quarterly			Resident #76 unattended wh	
	Assessment date	ed 11/24/11 indicated the			using the bathroom by Janu 14, 2012, by the Staff	ary
	resident was cog	gnitively intact, required			Development Coordinator or	her
	extensive one-pe	erson physical assistance			designee.	
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete Event ID:	THWH1	Facility I	ID: 000072 If continuation s	heet Page 23 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE			
		155152	B. WIN	G		12/15/20	011		
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE				
MONTIC	ELLO ACCIOTED I	NAME AND LIE ALTHOUGH			MAIN ST				
		IVING AND HEALTHCARE			CELLO, IN47960				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)		
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE		
		oulation, and toilet use,		0			5.112		
	1	ring transitions and							
	1	actional impairment of							
	both lower extremities, and had no falls.				How will you identify other resident having the potential to be affected to be affected.				
					the same deficient practice and v	-			
	A fall risk assess	sment dated 8/30/11			corrective action will be taken?				
		ident "has diagnosis of							
		ates evidence of impaired							
	gait/balance" and "is confused and/or disoriented" The assessment indicated the resident was at risk for experiencing falls.				 Residents who have alarm place to alert staff of unassisted 	is in			
					transfers have the potential to be				
					affected by the alleged deficient practice.				
					practice.				
					· The Plans of Care and the	1			
	A resident care p	olan dated 12/20/11			Assignment sheets of residents wi alarms in place to alert staff of	th			
	indicated "Res	ident is at risk for falls			unassisted transfers were reviewe	I			
	and has had an a	ctual fall10/18/11		December 14, 2011 while the surveyors were still in the building and updated as needed to reflect the need to stay with residents whenever alarms are turned off to provide care.					
	Pressure alarm to	o chair, 9/19/11Motion							
	sensor at bedside	e. Check placement and							
		very) shift and PRN (as			on to provide sais:				
	needed)"				The Plans of Care and the	1			
					Assignment sheets of residents wi alarms in place to alert staff of	tn			
	_	olan dated 9/8/11			unassisted transfers were reviewe	I			
		derate impaired cognition.			December 14, 2011 while the survivere in the building and updated a	*			
	_	reased periods of			needed to reflect the need for the	alarm.			
	confusion"				Staff will be re-educated o	n the			
		to distinct the second			purpose of alarms and the need to	1			
		ers recapitulation dated			with residents whenever alarms and turned off to provide care by Janua	-			
		indicated "9/19/11			2021 by the Staff Development	ary 14+,			
		bedside to alert staff of			Coordinator or her designee.				
		out of bed unassisted.			· A Post Test will be adminis	stered			
		t and function alarm			SSC 1000 Will bo duffilling				
	every shift" and "10/18/11 Pressure								
		n wheelchair to alert staff			What many was will be wet				
	or attempts to ge	et unassisted (sic). Check			What measures will be put	INTO			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE					
AND PLAN	OF CORRECTION	155152		LDING		12/15/20	
		100102	B. WIN		DDDDGG GYMY GM ME GYD GODD	12/13/20	J11
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE			CELLO, IN47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
placement and function every shift"				place or what systemic			
					changes you will make to ensure that the deficient		
	A nurses' note da	ated 11/9/11 at 4:55 A.M.			practice does not recur?		
	indicated "Res (r	resident) was getting her			practice accomernous		
	clothes from clos	set & went to turn around					
	to walk to bed &	lost balance falling					
	backwards hittin	g middle of back on foot			 Staff will be re-educated of purpose of alarms and the need to 		
	board of bed. Br	uise red-purplish forming			with residents whenever alarms ar	re ´	
	6 cm (centimeter	rs) - 3 cm left of			turned off to provide care by Janua 2012 by the Staff Development	ary 14,	
	spineWriter ou	tside room & 0 (no)			Coordinator or her designee.		
	witness fall, assisted Res to bed" A "Post Fall Investigation" dated 11/9/11						
					 A Post Test will be adminis 	stered.	
					· Aide Assignment sheets a	re	
	indicated "The	unit charge nurse was		updated daily, excluding weekends and holidays, to reflect changes in the			
	assisting her and	then stepped to the med					
	(medication) car	t to obtain something for		residents' needs.			
	(resident #76 nar	ne). (Resident #76 name)			· Change of condition is pas		
	then attempted to	turn by herself, lost her			on at change of shift on the weeke and holidays.		
	balance and fell.				and nondays.		
					· Each resident's Plan of Ca		
	An "Employee C	Communication Form"			reviewed and updated quarterly and as needed to reflect the residents' needs.		
	dated 11/10/11 ii	ndicated "Residents that			necuca to relicut the restaetits the	cus.	
	are fall risk & ha	ve interventions are not			· The Charge Nurse will ens		
	to be left unatten	ded"			that nursing measures are in place shift for residents who have alarms		
					the care plan by conducting round		
	A resident care p	olan dated 12/20/11					
	indicated docum	entation was lacking					
	related to not lea	ving the resident			How the corrective action(s	,,	
	unattended while	-			will be monitored to ensure	-	
					deficient practice will not re		
	A "Resident Pro	gress Note" dated 12/6/11			i.e., what quality assurance		
	at 1:15 P.M. indi				program will be put into place?		
	attempting to tak	te self back to W/C			· The CQI tool 'Fall		
		n bathroom. Did not use			Management' will be utilized	by	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		155152	A. BUI B. WIN			12/15/2	011
AND PLAN	SUMMARY S' (EACH DEFICIEN REGULATORY OR call light to notif finished. Upon er lying on back on noted" A "Post Fall Inve- indicated "Staf- the bathroom and herself. She fell of transfer"	155152	A. BUI	LDING IG STREET A 1120 N		COMPL 12/15/2 12/15/2 ekly ee nsure nd the o	ETED
	dated 12/7/11 inc has an alarm in c	dicated "When someone hair DT (due to) fall risk, left unattended in B/R			 and/or disciplinary action. The Director of Nursin her designee is responsible t monitor for compliance. 	-	
	An "Event Report indicated " Was witnessed No put into place to	s fall What intervention(s) was			Compliance Date: January 2012	14,	
	•	•					
	LPN #1 indicated cognitively impa indicated on 11/9 resident alone to	13/11 at 10:10 A.M. with d the resident was ired and "stubborn." She 0/11 the nurse left the go to a cart outside the ident fell. LPN #1					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155152		LDING	NSTRUCTION 00	(X3) DATE COMP 12/15/2	LETED	
	PROVIDER OR SUPPLIER	I IVING AND HEALTHCARE	STREET A	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	been left alone in indicated on 12/6 resident alone in resident "should Review on 12/14 facility policy an revised on 7/04, by the Executive current, and title Program" indicate communicate the for each resident on each shiftTl	ident should not have in the room. LPN #1 6/11 a CNA left the the bathroom and the not have been left alone." 1/11 at 8:25 A.M. of a and procedure dated 7/01, 1/19/06, and 3/10, provided and "Fall Management and "Charge nurses will be specific care required to the assigned caregiver the care plan will be dated, as necessary"				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE (X3) DATE SURVE COMPLETED 12/15/2011			ETED		
	ROVIDER OR SUPPLIER	VING AND HEALTHCARE		1120 N	MAIN ST CELLO, IN47960		
			ID PROVIDER PREFIX (EACH CORREC CROSS-REFERE)		CELLO, IN47900	, IN47960 	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0329 SS=D	from unnecessary drug is any drug w (including duplicat duration; or without without adequate in the presence of accordinate the dose of discontinued; or arreasons above. Based on a compresident, the facility residents who have drugs are not give antipsychotic drug treat a specific cordocumented in the residents who use gradual dose reduinterventions, unlein an effort to disconsensed on a revier facility failed to non-pharmaceuti attempted prior to needed Lorazepa medication) for 1 antianxiety medication (Resident #63). Findings include Resident #63's clareviewed on 12/1 record indicated with diagnoses with the presence of according to the property of the pro	cal interventions were o administration of as m (antianxiety of 4 residents on cations in a sample of 17.	F0	329	F329 Drug Regimen is Free from Unnecessary Drugs It is the practice of this providensure that non-pharmaceut interventions are attempted adocumented prior to administration of an antianximedication. What corrective action(s) was be accomplished for those residents found to have be affected by the deficient practice?	der to ical and ety	01/14/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155152	B. WIN	G		12/15/2011	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
MONITIO	ELLO ACCIOTED I	IVINO AND LIEAL TUGADE			MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTI	CELLO, IN47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ION
TAG	_	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!)	DATE	
	anxiety.				· Resident #63's antian	xietv	
					medication is being adminis	-	
		ders recapitulation dated			per physician's order.		
		indicated Lorezapam 0.5			Non phormocological		
		tab (tablet). Take 1 tablet			 Non-pharmacological interventions are attempted 	and	
		trostomy tube) 3 times			documented prior to		
	1	mild - moderate			administration of prn antianx	iety	
	agitation"				medication for resident #63.		
	Madianian Ada	inistration December					
		ninistration Records					
	indicated:				How will you identify other		
	N. 1 2011	.1 1 1 11			residents having the poten	tial	
		- the lorazepam had been			to be affected by the same		
		11/4/11, 11/21/11,			deficient practice and what corrective action will be tall		
	` ′), 11/26/11, and 11/29/11					
		nted interventions prior to					
		Review of behavior					
	_	ts and nurses' notes			 Residents with a physiciar order related to prn antianxiety 	's	
		nentation was lacking			medication use have the potential	to be	
	related to non-pl				affected by the alleged deficient practice.		
		ing attempted prior to the			practice.		
	administration o	i the lorazepam.			· The medical records for th		
	D 1 2011	.1 1 1 11			residents receiving a prn antianxie medication were reviewed and up	, I	
		- the lorazepam had been			as needed on December 13, 2011	while	
		12/7/11, 12/9/11,			the surveyors were still in the build	ling.	
	· ·	/11, and 12/12/11 without			Nursing staff were re-educ	ated	
		erventions prior to			on December 13, 2011 about the		
		Review of behavior			to attempt and document non-pharmacological interventions		
	_	ts dated November 1			before administering prn antianxie	ty	
	_	per 13, 2011 and nurses'			medication by the Nurse Manager team.	nent	
		ember 1 through			Cam.		
	December 13, 20				· Nursing Staff will be re-ed		
		vas lacking related to			on the need to attempt and docum		
	non-pharmaceut	ical interventions being			non-pharmacological interventions		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155152		LDING	00	12/15/201	
		100102	B. WIN			12/13/201	'
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
MONTIC	FILO ASSISTED I	IVING AND HEALTHCARE			MAIN ST CELLO, IN47960		
			_		02220, 114-7 000	<u> </u>	715
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
		to the administration of		1110	before administering prn antianxiet	tv	BILLE
	the lorazepam.				medication by January 14, 2012 by Staff Development Coordinator or designee.	the the	
	the Social Service	13/11 at 1:45 P.M. with ces Director indicated			· A Post Test will be adminis	tered.	
		re documented on					
	behavior monito	_			What measures will be put	into	
		ould have been attempted			place or what systemic		
	prior to the admi	nistration of the			changes you will make to		
	lorazepam.				ensure that the deficient		
					practice does not recur?		
		ocedure was requested					
	from the Social S	Services Director on					
	12/13/11 but was	s not provided for review			· Nursing Staff will be re-edu	ıcated	
	by the exit date of	of 12/15/11.	on the need to attempt and document			ent	
					non-pharmacological interventions before administering antianxiety		
	3.1-48(a)(4)				medication by January 14, 2012 by	y the	
				Staff Development Coordinator or h			
					· A Post Test will be adminis	tered.	
					· Behavior monitoring record		
					be reviewed on a daily basis, exclu weekends and holidays, by the	ıding	
					Interdisplinary team to ensure that		
					non-pharmacological interventions	are	
					attempted and documented before administration of prn anitianxiety	the	
					medication.		
							
					 The Medication Administra Record will be reviewed on a daily 		
					basis, excluding weekends and		
					holidays, by the Unit Manager or the designee to ensure that	neir	
					non-pharmacological interventions	are	
					attempted and documented before		
					administration of prn anitianxiety medication.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152			(X2) MULTIPLE CC A. BUILDING	00	(X3) DATE SURVEY COMPLETED 12/15/2011		
NAME OF F	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST				
MONTIC	ELLO ASSISTED LI	VING AND HEALTHCARE	MONTI	CELLO, IN47960			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Non-compliance with facili policy and procedure may result in employee re-education and/or disciplinary action.			
				How the corrective action(s will be monitored to ensure deficient practice will not r i.e., what quality assurance program will be put into pla	e the ecur,		
				The CQI tool 'Unnecessary Medications' be utilized by the Interdiscip team weekly times four, mor times three and quarterly thereafter to ensure complia The CQI committee reviews the audits monthly a action plans are developed i threshold of 90% is not met ensure continual compliance Non-compliance with facility policy and procedure result in employee re-educa and/or disciplinary action. The Director of Nursir Services or her designee is responsible to monitor for compliance.	linary inthly ince. and if the ito ie. may ition		
				Compliance Date: January	14,		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING B. WING (X3) DATE SU COMPLET 12/15/20			ETED	
` '	MENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN47960 ID PROVIDER'S PLAN OF CORRECTION (X5)				` ′
· ·	UST BE PERCEDED BY FULL IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
12/14/11 at 10 A.M. At 10:15 A.M., the B was found to have a l Maintenance Supervitime that those were the shower room but hallway. At 10: 25 A.M., the room was found to have a limited that those were the shower room but hallway.	ble environment for a public. In and interview the are that all equipment a safe and functional a facility. (BCD unit, 1 unit, and Cottage 2 Dur was completed a Supervisor and the aundry Supervisor on BCD shower room thoyer lift in it, the isor indicated at that not to be stored in along wall in Cottage 1 shower ave four half tiles the middle in front of the esident is taken out faintenance at that time that he	F04	465	F465 Safe/Function/Sanitary/Comable Environment It is the practice of this providensure that all equipment in resident areas is safe and functional. What corrective action(s) with the accomplished for those residents found to have been affected by the deficient practice? The hoyer lift has been removed from the shower roomover were replaced on December 14, 2011 while the surveyors were still in the building. The shower head in the West shower room was repair on December 14, 2011 while surveyors were still in the building. The call light in Room 2	ill en om. e 1 e 2 ired the	01/14/2012

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED			
		155152	B. WIN	G		12/15/2	011
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE	1120 N MAIN ST MONTICELLO, IN47960				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	At 11:05 A.M., t shower head nea had part of the co	the 2 West unit the restricted the base of the handle oil of the cord missing on nee Supervisor indicated			was replaced on December 2011 while the surveyors we still in the building. Even the the call light did not light up i resident room, it did still sour the nurse's station.	re ugh n the	
	on the Cottage 2 light did not ligh Maintenance Suj	when testing the call light unit, Room 247's call at up when pulled. The pervisor indicated at that ust be burned out.			How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken		
	3.1-19(f)				 All residents have the potential to be affected by the alleged deficient practice. The facility ensures the equipment in resident areas safe and functional. Staff will be re-educated or importance of notifying the Mainter Supervisor or his designee with an concerns about resident equipment the Maintenance Supervisor or his designee by January 14, 2012. 	at all is the nance y	
					What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur?		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		A. BUIL	DING	NSTRUCTION 00	(X3) DATE COMPL 12/15/2	ETED	
		100102	B. WING		DDRESS, CITY, STATE, ZIP CODE	12/10/2	
NAME OF P	ROVIDER OR SUPPLIER				MAIN ST		
MONTIC	ELLO ASSISTED L	IVING AND HEALTHCARE		MONTIC	CELLO, IN47960		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFTING INFORMATION)		TAG	BEITELENETY		DATE
					Staff will be re-educated or importance of notifying the Mainter Supervisor or his designee with an concerns about resident equipmen the Maintenance Supervisor or his designee by January 14, 2012. A Post Test will be adminis The Maintenance Supervish his designee will ensure implemen or compliance by conducting round routinely to ensure that all equipmer resident areas is safe and function Non-compliance with facility policy and procedure may result in employee re-education and/or disciplinary action.	nance y tt by tered. or or tation ds ent in al.	
					How the corrective action(s will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into pla The CQI tool 'Facility Environmental Review' will be utilized by the Interdisciplinar team weekly times four, mon times three and quarterly thereafter to ensure compliant. The CQI committee reviews the audits monthly a action plans are developed if threshold of 90% is not met to	e cy thly nce.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152			(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155152	B. WING		12/15/2011
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE	
MONTIC	ELLO ASSISTED LI	VING AND HEALTHCARE		N MAIN ST TICELLO, IN47960	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710	REGULATION ON	LEGE IDENTIFICATION OF THE OTHER PROPERTY.	me	ensure continual compliance	
				 Non-compliance with facility policy and procedure result in employee re-educat and/or disciplinary action. The Maintenance Supervisor or his designee is responsible to monitor for compliance. 	ion
F0514 SS=D	each resident in according professional stand complete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission screes tate; and progress Based on recording facility failed to a resident's pulse with medication with less than 60 and the intakes for a resident practice.	paintain clinical records on accordance with accepted ards and practices that are ely documented; readily stematically organized. must contain sufficient tify the resident; a record of assments; the plan of care ded; the results of any ening conducted by the s notes. review and interview, the accurately document a when administering a hold parameters for pulse failed to document fluid dent on fluid restriction. ctice impacted 2 of 17 and. [Residents #56 and	F0514	Compliance Date: January 2012 F514 Clinical Records It is the practice of this provio maintain clinical records on e resident in accordance with accepted professional standard practices that are compliance accurately documented; reac accessible; and systematical organized.	01/14/2012 der to each ards ete; dilly

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII		INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155152	B. WIN			12/15/2011
	PROVIDER OR SUPPLIE	R LIVING AND HEALTHCARE		1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
TAG	Findings included 1. On 12/12/11 at facility was initing Practical Nurse was identified with interviewable, at the second was included, but we depression, and pure delusions, and pure d	at 9:45 A.M., tour of the lated with Licensed [LPN] #1. Resident #86 with a fall history, and up without assistance. 12:45 P.M., Resident serviewed. Diagnoses are not limited to, anxiety, mia, dementia with sychotic behaviors. Indeed, but was not molol 50 milligrams by ly Hold for pulse less		TAG	What corrective action(s) be accomplished for thos residents found to have b affected by the deficient practice? The facility maintains ac and complete clinical recorrelated to documentation or Resident #86's pulse when administering medication whold parameters. The facility maintains ac and complete clinical recorrelated to fluid intakes for Resident #56. How will you identify other residents having the pote to be affected by the same deficient practice and what corrective action will be taken a parameters with medication administration have the potential affected by the alleged deficient practice. Medical records of reside physician orders related to fluid and pulse parameters with medication administration were reviewed and updated as needed to reflect the resident's needs.	will e een curate ds f with curate ds at aken? an pulse l to be ents with ntake cation d
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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/15/2011	
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE			•	1120 N	ADDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN47960	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR on a fluid restric	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) tion. The nurse indicated		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE PRIATE	(X5) COMPLETION DATE
	fluid restriction. The clinical recoreviewed on 12/ Diagnoses included to, end-stage ren	rd for Resident #56 was 13/11 at 1:15 P.M. ded, but were not limited al disease with sulin-dependent diabetes,			Nurse staff will be re-ed regarding documentation relate intake and pulse parameters wi medication administration by th Development Coordinator or he designee by January 14, 2012. A Post Test will be adm	d to fluid th e Staff er	
	depression and anxiety, coronary artery disease with past by-pass surgery, obstructive sleep apnea, and gastroesophageal reflux disease.				What measures will be possible place or what systemic changes you will make to ensure that the deficient practice does not recur?		
	cc. [cubic centing fluid restriction.] was to provide "daydivided to pure breakfast, 240 cc with supper." The was to provide "night shift, 300 cand 320 cc. for the control of the contr	physician ordered the			Nurse staff will be re-ed regarding documentation relate intake and pulse parameters will medication administration by the Development Coordinator or he designee by January 14, 2012. A Post Test will be adm The Unit Manager is rest to ensure documentation relate intake and pulse parameters will medication administration has completed and documented as by performing routine audits of	d to fluid th e Staff er inistered. sponsible d to fluid th been ordered,	
	day. The Dietar provide 350 cc. a Department was day.	reduced to 1600 cc. per by Department was to a day, and the Nursing to provide 1240 cc. per on 12/13/11 at 12:50 56 indicated he was			by performing routine audits of medical records of those reside fluid restrictions and pulse para The Staff Developm Coordinator or her designed ensure implementation or compliance by conducting skills validations.	nts with meters. nent ee will	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		LDING	ONSTRUCTION 00	(X3) DATE COMPI 12/15/2	LETED	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MONTICELLO ASSISTED LIVING AND HEALTHCARE				MAIN ST CELLO, IN47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	room, and got a	no water pitcher in his cup of ice on his meal ent indicated "the nurses"		Non-compliance with facil policy and procedure may result i employee re-education and/or disciplinary action.	•	
	A.M., the Direct the amount of flucture consumed for the allowance would	e Nursing Department I be documented on the		How the corrective action(will be monitored to ensur deficient practice will not r i.e., what quality assurance program will be put into pl	e the ecur, e	
	Record]. The arm with meals woul "Food/Fluid Inta	nount of fluids consumed d be documented on the ke Record" forms.		The CQI tools titled 'Documentation Mar/Tar Flowsheets' and 'Fluid Restrictions' will be utilized Interdisciplinary team weekl times four, monthly times th	у	
	restriction order	11 M.A.R. listed the fluid from 5/25/11 as a our Information"]. The		and quarterly thereafter to e compliance.		
	documented.	ed each shift were not 11 "Food/Fluid Intake		The CQI committee reviews the audits monthly action plans are developed threshold of 90% is not met	if the to	
	Record" had inta	ke amounts documented or breakfast, 240 cc. for		Non-compliance with facil policy and procedure may result i employee re- education and/or disciplinary action.	ity	
		otals for amount of fluids ch 24 hour period.				
	order from 5/25/ was documented	2011 M.A.R. listed the 11 as a "F.Y.I." Nothing related to the amounts of until the order was		Compliance Date: January 2012	/ 14,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		A. BUIL	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING (23) DATE SURVEY COMPLETED 12/15/2011				
NAME OF PROVIDER OR SUPPLIER MONTICELLO ASSISTED LIVING AND HEALTHCARE			B. WING	STREET A 1120 N I	DDRESS, CITY, STATE, ZIP COI MAIN ST CELLO, IN47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	was documented evening shift; on documented for the and 300 cc. for the shift. The November, 2 Record" had intacc. for breakfast; and 240-480 cc. There were no to fluids consumed In the interview of A.M., the Director the facility pharm M.A.R.s, and was listed with a	tals for the amount of for each 24 hour period. on 12/15/11 at 10:10 or of Nursing indicated hacy provided the s not sure why the order "F.Y.I." designation. December, 2011 M.A.R.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLET		ETED	
		155152	B. WIN	IG		12/15/20)11
	PROVIDER OR SUPPLIER	VING AND HEALTHCARE	•	1120 N	DDRESS, CITY, STATE, ZIP CODE MAIN ST CELLO, IN47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0214	(a) An evaluation of each resident shall admission and shall semiannually and change in the reside licensed nurse shall needs of the reside Based on record facility failed to a Evaluation prior facility. This importants reviewed in (Resident R4) Residential finding The clinical reconserviewed on 12/1 Resident was admitted by the control of the clinical reconserviewed on 12/1 Resident was admitted by the control of the clinical reconserviewed on 12/1 Resident was admitted by the clinical reconserviewed on 12/1 Resident Resident was admitted by the clinical reconserviewed on 12/1 Resident Resi	of the individual needs of I be initiated prior to all be updated at least upon a known substantial dent's condition, or more nt's or facility's request. A all evaluate the nursing ent. review and interview, the do a written Resident to admittance to the eacted 1 of 6 Residential in a sample of 6. Ings include: Ind of Resident R4 was 1.5/11 at 8:50 A.M. mitted on 10/3/11. Ided but were not limited essure, diabetes, and thy. In Evaluation was not sisten Assessment was of admittance to the sisten Assessment in the week is wife were admitted. The	R	0214	R214 Evaluation It is the practice of this provion that a written evaluation of the individual needs of each resi is initiated prior to admission. What corrective action(s) whose accomplished for those residents found to have been affected by the deficient practice? An evaluation of Resident I has been done since admission. How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be taken the potential to be affected by the alleg deficient practice.	ee dent . ill en R4 tial	01/14/2012
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/15/2	ETED		
		100102	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	12/10/2	011	
NAME OF PROVIDER OR SUPPLIER					MAIN ST			
MONTICELLO ASSISTED LIVING AND HEALTHCARE			MONTICELLO, IN47960					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE		
	determined he was appropriate. There was nothing written down, no formal evaluation.				All residential residents will receive a written evaluation prior to admission. Nurse staff will be re-educated.)		
					regarding documentation related to pre-admission evaluation by Janua 14, 2012 by the Staff Developmen Coordinator or her designee.	o ary		
					· A Post Test will be adminis	stered.		
					What measures will be put place or what systemic changes you will make to ensure that the deficient practice does not recur?	into		
					Nurse staff will be re-educa regarding documentation related to pre-admission evaluation by Janua 14, 2012 by the Staff Developmen Coordinator or her designee.	o ary		
					· A Post Test will be adminis	stered.		
					 All residential resident receive a written evaluation p to admission. 	-		
					 The Interdisciplinary T will ensure implementation o compliance by reviewing the pre-admission evaluation pricacceptance of admission. 	r		
					Non-compliance with facilit policy and procedure may result in			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A DULL DING 00			(X3) DATE SURVEY COMPLETED		
		155152	A. BUILD			12/15/2	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					MAIN ST		
MONTICE	ELLO ASSISTED L	IVING AND HEALTHCARE			CELLO, IN47960		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY) employee re-education and/or				DATE
					disciplinary action.		
					How the corrective action(s	s)	
					will be monitored to ensure	the	
					deficient practice will not re		
					i.e., what quality assurance program will be put into place?		
					program win be put into pie	ice:	
					The tool "Evaluation		
					Agreement for Residential Healthcare Services" will be		
					utilized by the Interdisciplina	ry	
					team prior to admission to the	e	
					Residential Unit.		
					· The Medical Records	of	
					new admissions will be revie		
					by the Interdisciplinary Team within 24 hours after an	1	
					admission, excluding weeke	nds	
					and holidays, to ensure the		
					evaluation agreement has be completed.	een	
					· The CQI committee		
					reviews the audits monthly a		
					action plans are developed in threshold of 90% is not met		
					ensure continual compliance		
					· Non-compliance with facili	·V	
					policy and procedure may result in	-	
					employee re- education and/or disciplinary action.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155152		A. BUI	a BUILDING 00			X3) DATE SURVEY COMPLETED 12/15/2011	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
		IVING AND HEALTHCARE			MAIN ST CELLO, IN47960			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	